How Health Access Workers Measure Outcomes for Community Based Care Coordination

Indiana Community Health Worker Symposium

Indiana State Department of Health

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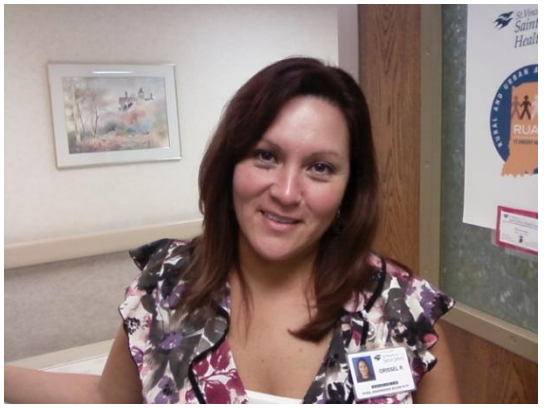
Why We Do What We Do:
"A Whole Different Kind of 99%-ers"

- 1% = for 25% of health care costs
  - Avg, $100,000 per year in ER, hospital, MD visits and RX
- 5% of patients =50% of all healthcare spending
  - *consume 55% of all healthcare services*
- *Contributing factors: chronic disease (diagnosis, treatment, management); health care coverage; financial resources; provider access; system complexity; social support*



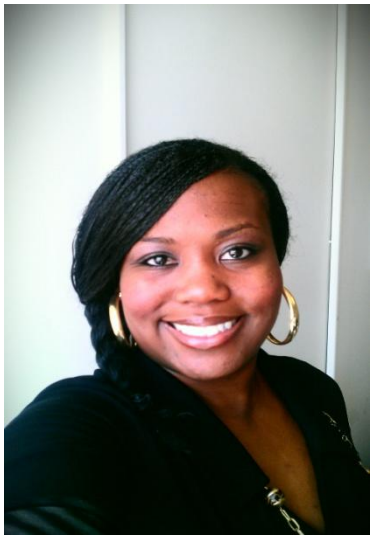
Why We Do What We Do: Indiana's Vulnerable Citizens (A Snapshot)

- 6.5 million Hoosiers
- 21% of Hoosiers live in poverty
- 1.1 million Hoosiers = some type of Public Assistance (i.e. Medicaid coverage, etc.)
  - 180% Increase in Food Stamp Recipients in the last 10 years
- 800,000+= Medicare Coverage
- 800,000+ = Uninsured
- 47% of Hoosier public school kids receive free/reduced lunch

Indiana's Health: Hoosier Snapshot

- High % teens giving birth
- Low Birth weight %
- Overweight
- Heart Disease
  - High Blood Pressure
- Diabetic
- Smokers
- Model that tends to be treatment/procedure oriented vs. preventative health/wellness/disease management oriented….

Why We Do What We Do: Opportunities:



- Provide/increase access: "the 5 rights"
  - Right Care
  - Right Time
  - Right Place
  - Right Provider
  - Right Payer
- Quality, evidence-based clinical/public health care is provided consistently to all
- Become better stewards of existing resources: both human and financial: minimize duplicative and/or repetitive processes and services
- Work with key partners and stakeholders to "own" this work <u>together</u>: as a community
- Demonstrate outcomes that make a real & observable impact (documented!)
- **Meaningful differences/improvements in the lives of our friends, families and neighbors**

Who We Are:
Rural and Urban Access to Health (RUAH)

Purpose:

To connect our friends, family, and neighbors to a comprehensive, integrated delivery network of health, human and social services resulting in improved access and removal of barriers to needed resources.

Meaning and Mission:

The word *ruah*, in yiddish

means **"Breath of Life".**

The Goal?

…to breathe new life into a health care system to better serve our most vulnerable community members

How We Got our Start: (a little history)

- RUAH Partnership initiated: 2000
  - SV Health
    - *Inpatient, Outpatient medical care provider*
  - Indiana Health Centers, Inc.
    - *Federally Qualified Health Center (FQHC)*
  - Health and Hospital Corporation of Marion County
    - *County Health Department*
  - ADVANTAGE Health Plans, Inc.
    - *Insurance Provider (public and private plans)*
  - Butler College of Pharmacy, later added
    - *Pharm D students*
    - *Pharmaceutical Assistance Program (PAP) Consultation*
    - *Project Management / Oversight*
  - Community Interface Groups: local partner groups responsible for program implementation.
    - *Health centers, health departments, physician offices, civic groups, and health, human and social service agencies*

- Funded by HRSA, Ascension Health from 2001-2005
- Additional private funding through the Anthem Foundation: establish 3 additional sites
- Sustained through local hospital funding and captured reimbursement through enrollment efforts

How We Do our Work: Our Resources

- 9.5 HAW's
- 6.5 MAC's
  - Direct Hires
  - Community-agency based
- System Administrative Support
  - 1 Health Access Manager
  - 1 Operations Facilitator
  - 1 Administrative Assistant
  - 3 Language Access Staff
  - 1 System Director
- Annual Budget
  - $1.1 million

What We've Done So Far: Program Outcomes

- Four community programs expand to Eight community programs

- Outcome Focused: Pathway Model Integration
  - 5 Pathways implemented
  - Data reporting effective 9/11
  - Used to count what we did "to/for" clients vs. outcomes!

- AHRQ Innovation Site
- Community Care Coordination Learning Network Site
- National Institute of Health Research Partner
- Indiana CHIPRA grantee
- Madison County Community HUB

Integration with Federal, State and County Stakeholders

- $39.8 million worth of low/no cost drugs provided

- Language Access
  - 1253 interpreters trained through Bridging the Gap
  - 1094 documents translated

How We've Changed: Moving from a Volume Based to an Outcome Based Measurement Model

Our 1st 8 years:

1. Counted number of encounters
2. Recorded initial vs. follow up visits
3. Reported <u>EVERY thing</u> we did
    1. To
    2. For
    3. With

    Our Clients
4. High Volume; Low Outcome Measurement

- Our last two years, and moving forward:

1. Record number of clients referred to us for a baseline
2. Collect Barriers
3. Report Pathways
    1. Opened
    2. In-Progress
    3. Completed
    4. Incompleted
4. Starting the Benchmarking and ROI Process

How & Why We Decided on PATHWAYS:

1. Best Practice Research
2. Communicating with our "sister programs"
3. Assessing how other disciplines were doing their work and/or changing how they viewed their work
4. "Scanning" the environment for current and future changes
5. Address how all of the above fit with our goal, our mission and our sustainability

Focusing on Outcomes

The Pathways Model

1 **Find** — Identify individuals who are most at risk

2 **Treat** — Confirm evidence-based intervention

3 **Evaluate** — Measure the outcome in health and cost savings

<u>Example:</u>

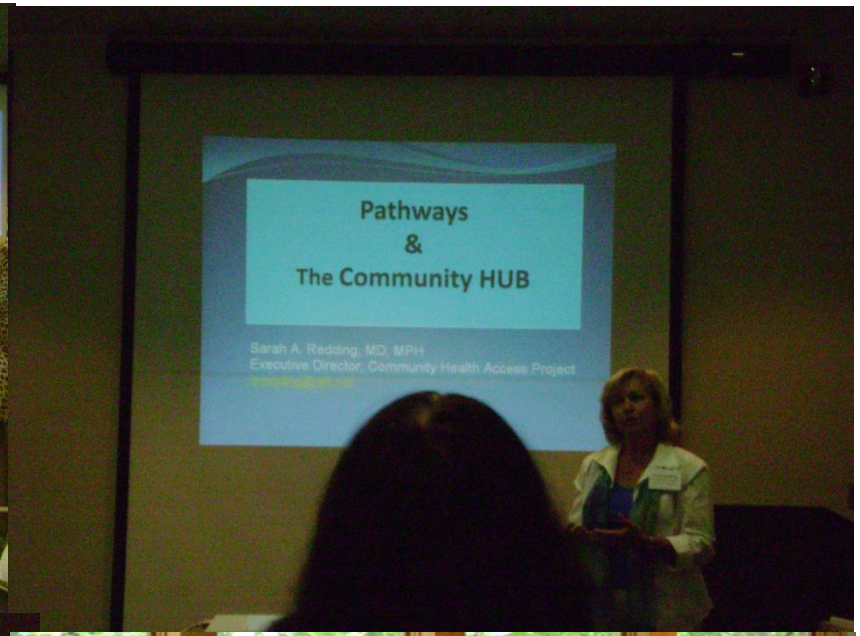
Identify pregnant women—confirmed by pregnancy test

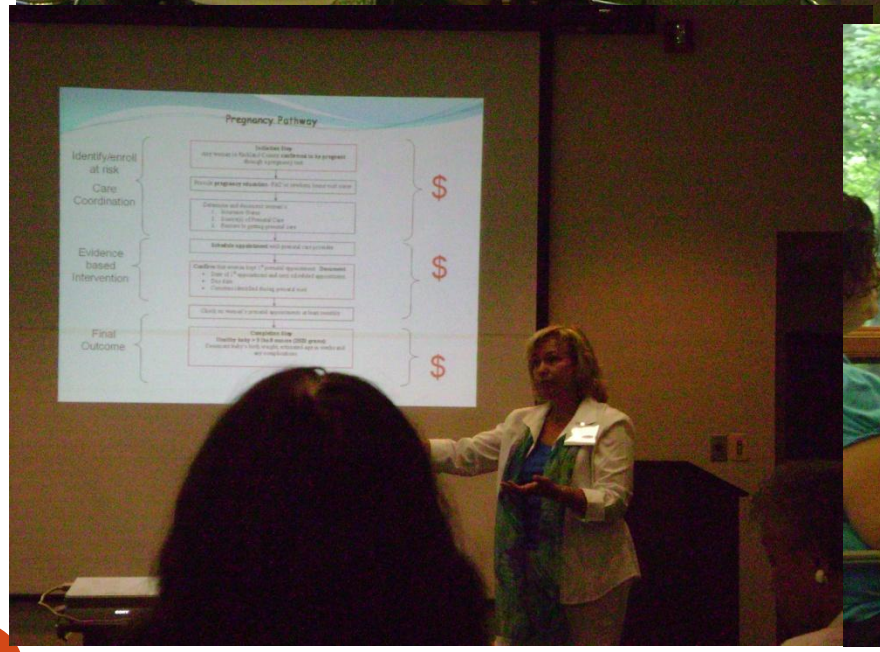
Confirm patient kept monthly appointments with prenatal care provider

Healthy baby weighing more than 5lbs. 8oz.

How We Design our Pathways:

1. Review and Discuss Available Data and Community Input
2. Prioritize Areas of Focus
3. Discern and Decide the Desired Outcome *(start with the end goal in mind)*
4. Agree to the Initiation Step for the Pathway (*with whom and how does a specific Pathway get started)*
5. Identify the KEY steps that are consistently taken to work towards a successful outcome
6. Identify barriers to be collected (*and later used as a way to problem-solve)*
7. Build the Measurement Tool
8. Start the Work


Pathways
&
The Community HUB
Sarah A. Redding, MD, MPH
Executive Director, Community Health Access Project


Pregnancy Pathway
Identify/enroll at risk
Care Coordination
Evidence based Intervention
Final Outcome
$
$
$

The Pathways Model: SVH RUAH

Medical Home

Medical Referral

Pregnancy

Social Services

Enrollment

HAW MONTHLY REPORT
September 2012

Source of Referral	
Field Based	283
Clinic/Office	134
Hospital	42
Emergency Room	38
Med Assist	10
SPN	4
Total	511

Participant Visit Location	
Home	52
HAW Office	384
ER	7
Community	22
Clinic/MD Office	31
Total	496

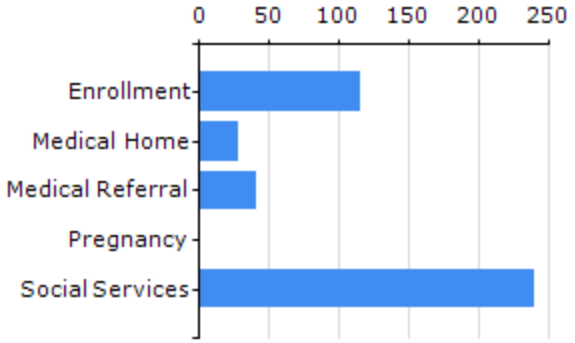
HAW MONTHLY REPORT
September 2012

Financial Class	
Uninsured	337
Private Insurance	43
Medicaid	78
Medicare	37
Other	7
HIP	2
VA Health Benefits	1
Total	505

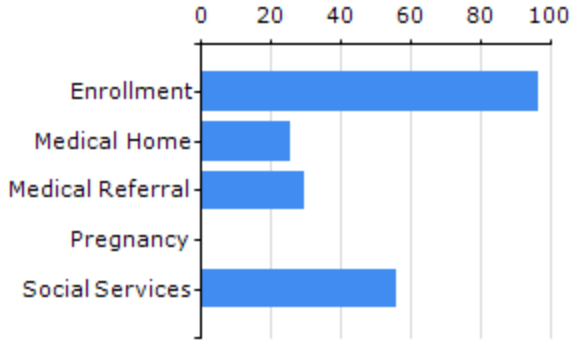
Initial vs. Follow-up Visits	
Followup Visit	328
Initial Visit	168
No Purpose Listed	15
Total	511

HAW MONTHLY REPORT
September 2012

Open Pathways	
Enrollment	116
Medical Home	29
Pregnancy	0
Medical Referral	41
Social Services	241
Total	427



Pending Pathways	
Enrollment	97
Medical Home	26
Pregnancy	0
Medical Referral	30
Social Services	56
Total	209



HAW MONTHLY REPORT
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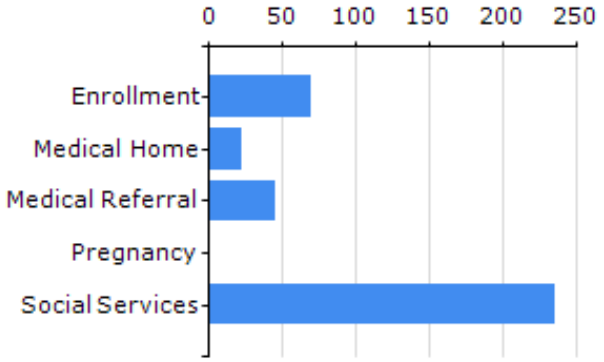
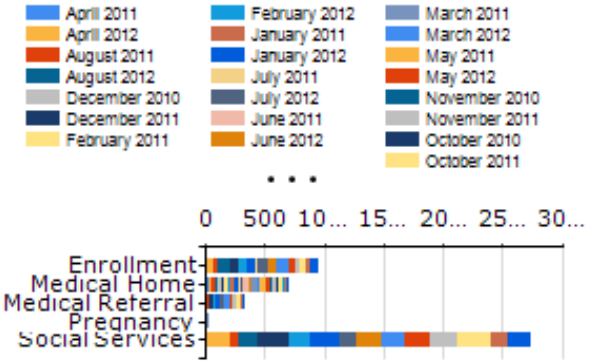
Completed Pathways	
Enrollment	70
Medical Home	23
Pregnancy	0
Medical Referral	46
Social Services	236
Total	375

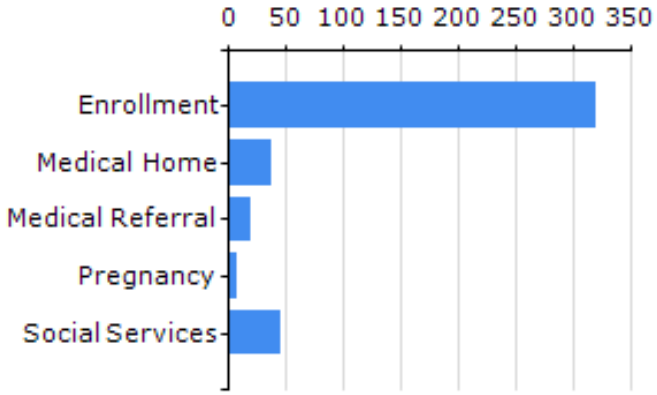


Completed Historical Pathways	
Enrollment	947
Medical Home	694
Medical Referral	327
Pregnancy	23
Social Services	2734
Total	4725



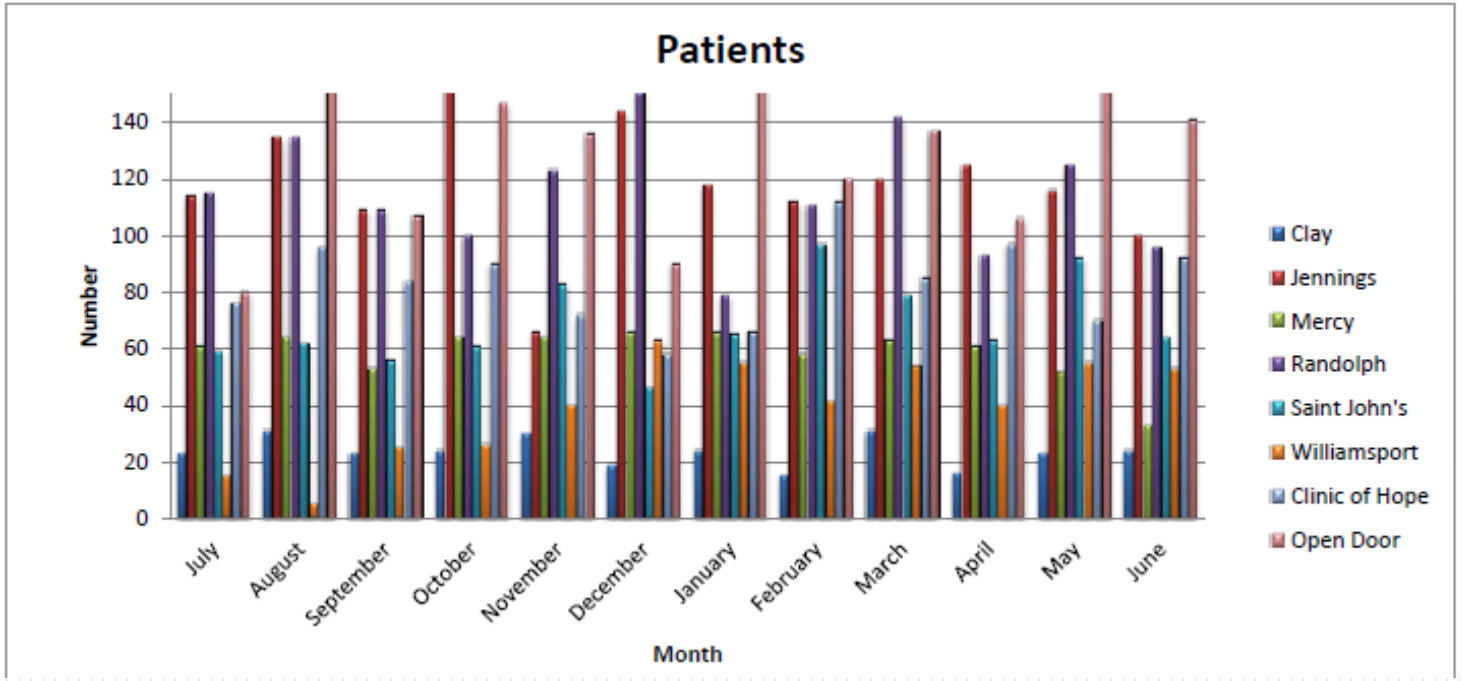
HAW MONTHLY REPORT
September 2012

Incomplete Pathways	
Enrollment	321
Medical Home	38
Pregnancy	8
Medical Referral	20
Social Services	47
Total	434

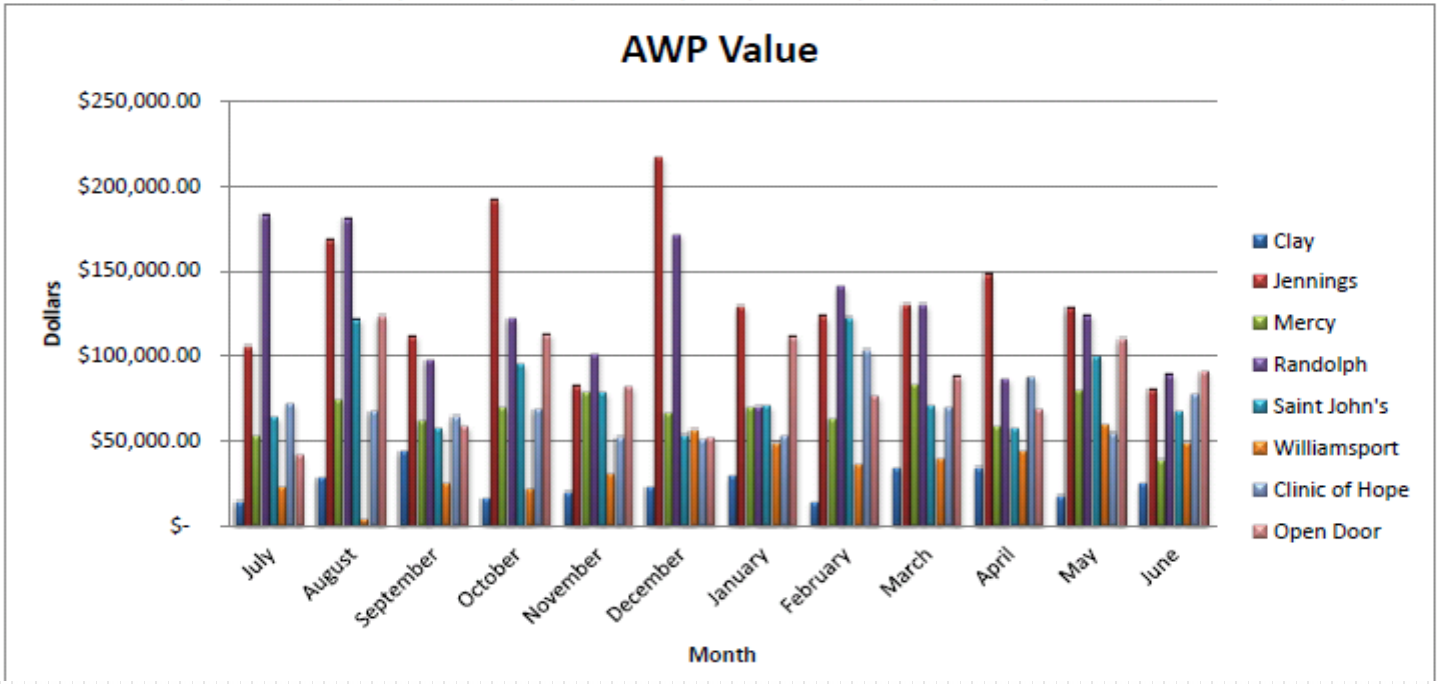


FY12

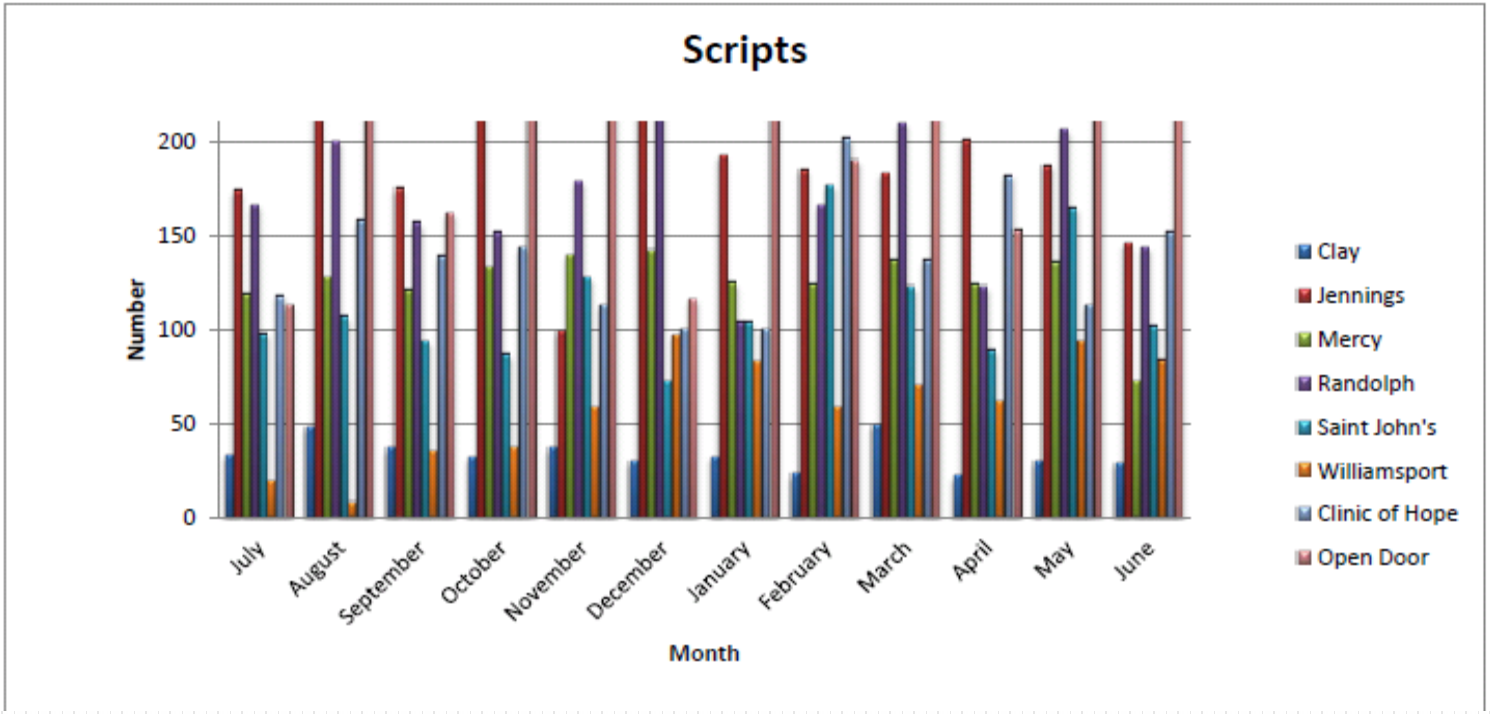
Patients	Clay	Jennings	Mercy	Randolph	Saint John's	Williamsport	Clinic of Hope	Open Door
July	23	114	61	115	59	15	76	80
August	31	135	64	135	62	5	96	180
September	23	109	53	109	56	25	84	107
October	24	155	64	100	61	26	90	147
November	30	66	64	123	83	40	72	136
December	19	144	66	151	46	63	58	90
January	24	118	66	79	65	55	66	157
February	15	112	58	111	97	41	112	120
March	31	120	63	142	79	54	85	137
April	16	125	61	93	63	40	97	106
May	23	116	52	125	92	55	70	157
June	24	100	33	96	64	53	92	141



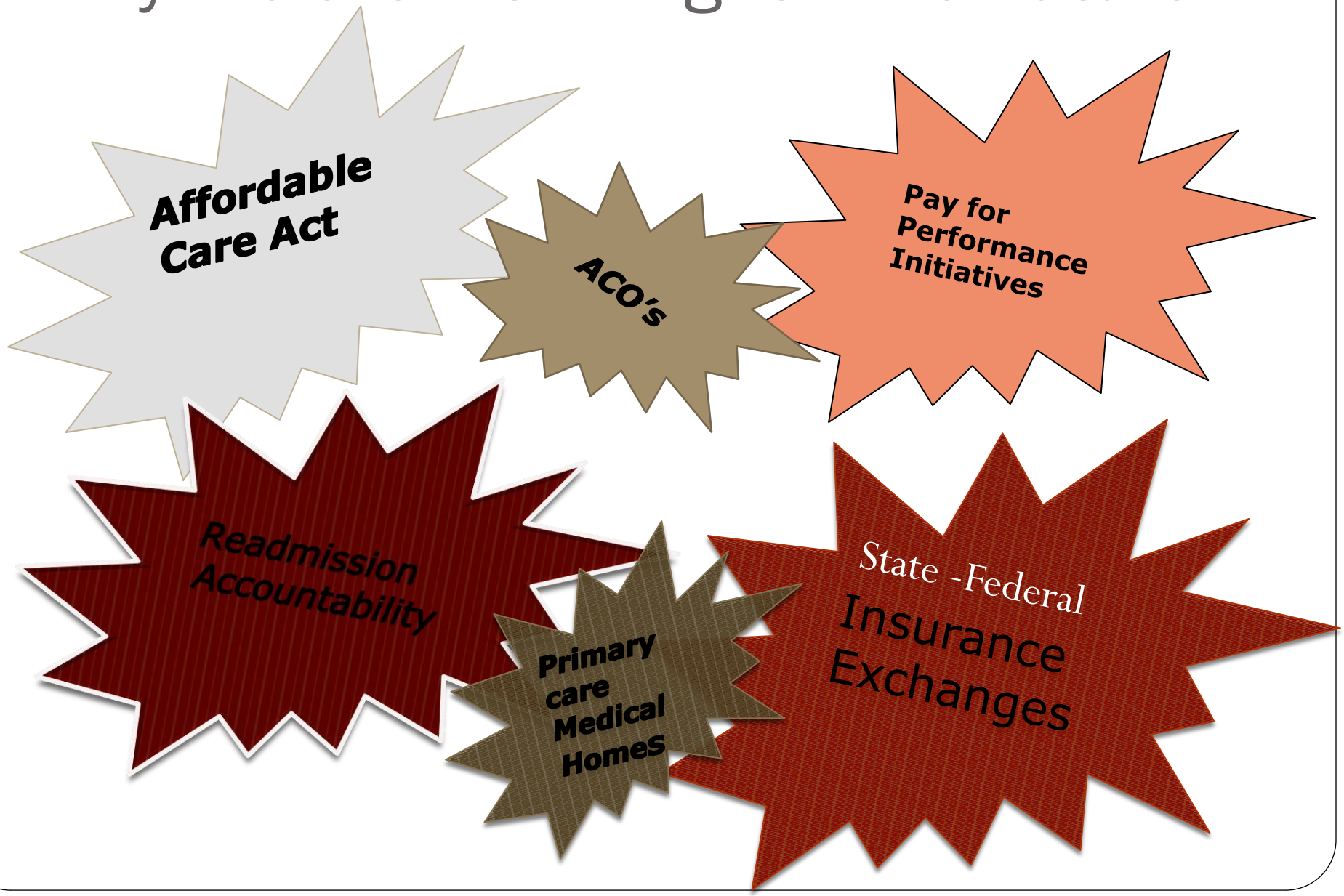
AWP Value	Clay	Jennings	Mercy	Randolph	Saint John's	Williamsport	Clinic of Hope	Open Door
July	$ 13,819.21	$ 105,357.57	$ 52,370.81	$ 183,183.34	$ 63,675.97	$ 22,342.47	$ 71,495.07	$ 41,686.63
August	$ 27,994.70	$ 168,631.12	$ 73,581.06	$ 181,033.04	$ 121,689.20	$ 3,035.70	$ 66,908.99	$ 123,322.20
September	$ 43,621.56	$ 111,520.19	$ 61,176.45	$ 97,300.04	$ 56,658.28	$ 24,248.55	$ 64,129.34	$ 57,662.15
October	$ 15,374.60	$ 192,300.90	$ 69,079.47	$ 122,075.55	$ 95,136.97	$ 21,358.27	$ 68,002.90	$ 112,680.97
November	$ 19,615.23	$ 82,747.72	$ 78,376.25	$ 101,082.02	$ 78,397.21	$ 30,054.38	$ 51,926.19	$ 81,720.43
December	$ 22,037.14	$ 217,174.74	$ 65,998.70	$ 171,545.35	$ 52,799.67	$ 56,328.64	$ 50,196.92	$ 51,187.60
January	$ 28,889.50	$ 129,031.30	$ 68,990.64	$ 69,662.86	$ 70,808.66	$ 48,535.67	$ 52,459.54	$ 111,588.09
February	$ 13,151.48	$ 123,729.88	$ 62,406.94	$ 141,255.90	$ 122,266.17	$ 36,014.67	$ 103,222.80	$ 76,384.17
March	$ 33,535.44	$ 130,039.09	$ 82,799.33	$ 130,038.06	$ 70,320.77	$ 39,328.46	$ 69,154.99	$ 88,243.06
April	$ 34,029.60	$ 148,433.80	$ 58,181.46	$ 86,440.57	$ 56,656.67	$ 43,197.76	$ 87,328.26	$ 68,135.62
May	$ 17,358.74	$ 128,291.93	$ 79,389.28	$ 123,585.13	$ 99,719.63	$ 59,039.85	$ 54,311.06	$ 110,056.59
June	$ 24,783.48	$ 80,151.75	$ 38,692.66	$ 89,248.47	$ 67,264.48	$ 48,182.38	$ 77,235.95	$ 90,857.69



Scripts	Clay	Jennings	Mercy	Randolph	Saint John's	Williamsport	Clinic of Hope	Open Door
July	33	174	119	166	98	19	118	113
August	48	218	128	200	107	8	158	336
September	37	175	121	157	94	35	139	162
October	32	247	133	152	87	37	144	267
November	37	99	140	179	128	58	113	226
December	30	241	142	236	73	97	100	116
January	32	193	125	104	104	83	100	285
February	23	185	124	166	177	59	202	190
March	49	183	137	210	123	70	137	218
April	22	201	124	123	89	62	182	153
May	30	187	136	207	165	94	113	287
June	29	146	72	144	102	84	152	223

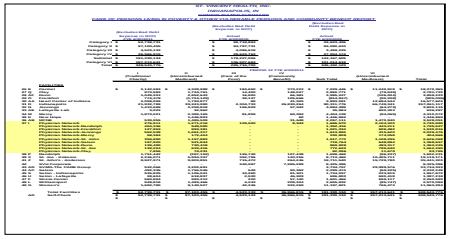


Why We are Planning for The Future:



How We Plan To Contribute:

- **Un/underinsured community members can receive care "sooner vs. later"**
- **Consistent and familiar care is provided along with follow up & follow through: treatment is across time and not episodic**
- **Resources are used as effectively as possible, including:**
  - **Human**
    - **Providers, Practitioners, Care Coordinators, Administrative support, etc.**
  - **Financial**
    - **Reimbursement, Funding, Cost-Avoidance, "Write-Off's"**
  - **Technological**
    - **Connecting Information in a timely, meaningful way**
  - **Support (wrap-a-round) Services**
    - **Connecting medical treatment, public health practices, & psychosocial principles**
- **Vital connections are made**
  - **Integrate and coordinate care <u>not</u> duplicate and replicate care**
  - **"Best Practice" Learning's are shared; and solutions are not "re-created"**



Questions?

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